Government of Newfoundland and Labrador
**Department of Health and Community Services**
**Physician Services Division**

# PROVIDER REGISTRATION FORM

***Please Print***



**IF YOU ARE:**

**A New Registrant** - complete all areas of this form.

**Updating Your Current Registration Information -** only complete areas where information has changed**. Provider Number** _____

**PERSONAL INFORMATION**

| Surname | | Given Name and Initial | | |
|---|---|---|---|---|
| ☐ Male ☐ Female | Date of Birth | Place of Birth | MINC Number | Social Insurance Number |

**PROFESSIONAL INFORMATION**

| Graduation Code (See Table 1 Attached) | Date of Graduation with Professional Degree | Professional Category (See Table 2 Attached) ☐ Medical ☐ Dental | |
|---|---|---|---|
| College of Physicians and Surgeons | Effective Date of Licence | Practice Start Date | Specialty For Which You Are Licensed To Practice (See Table 5 Attached) |
| email address | | | |

**PRACTICE INFORMATION**

| ☐ Solo ☐ Group | Activity Code (See Table 4 Attached) | Activity Start Date | | Activity Stop Date |
|---|---|---|---|---|
| Termination Code | Termination Date | Spec Start Date | Spec Stop Date | Sub-specialty Code (See Table 3 Attached) |
| Street/P.O. Box | | City/Town | | |
| Province | Postal Code | Telephone Number **(709)** | | |

**CORRESPONDENCE ADDRESS**
*(Only if different from Practice Address)*

| Street/P.O. Box | | City/Town |
|---|---|---|
| Province | Postal Code | Telephone Number **(709)** |

***Please complete over >***

# PROVIDER REGISTRATION FORM

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**PAYMENT INFORMATION**

**All payments will be paid using the banking information identified below.**
**If no banking information is provided payment will be by cheque.**

To whom do you Assign Your MCP Payments: ☐ Self ☐ Other*

Name of Other* _____ Identity # of Other _____

| Bank Name | Branch Number | Code Number | Account Number |
|---|---|---|---|
| | | | |

**"Assignment of Payment Agreement"**
**form must be completed.**

I hereby declare and affirm that I understand the content of all forms signed pursuant to this registration as a provider of service under the Newfoundland Medical Care Insurance Act, and that all information provided by me to MCP for purposes of this registration is accurate and true.

I acknowledge having reviewed and understand all pertinent information in relation to this registration with MCP, and I agree to abide by all terms and conditions therein contained, which terms and conditions shall form part of this application.

I agree to abide by the Newfoundland Medical Care Insurance Act and Regulations as they apply to the Medical Care Program or Dental Health Program.

Date _____ Signature _____

**MCP PROVIDER NUMBER:**

When all information is received and processed, a copy of this form along with a six (6) digit Provider Number will be forwarded to you. This Provider Number must be identified on all claims submitted to MCP.

**For Office Use Only**

**Date Keyed:** _____ **Initials** _____ **NEW PROVIDER NUMBER:** _____

**Board Information Date:** _____

**Provider Registration, Physician Services Division**
**57 Margaret's Place, P.O. Box 8700**
**St. John's, Newfoundland, Canada, A1B 4J6**
**Telephone: (709) 729-3508**
**Facsimile: (709) 729-5238**

***www.gov.nf.ca/mcp***